Sullivan Family Eye Care

William H. Jones, O.D.
117 S. Main Street
Sullivan, IN 47882

All copays/professional fees are required at the time of service. The material charges for glasses and/or contacts must be paid in full before the order can be placed.

Alternate financial arrangements can possibly be made, be sure to notify the front desk BEFORE treatment if you need to make such an arrangement.

We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription and to fit that particular frame. For these reasons, cash refunds are not possible. At the doctor's discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted at no additional cost, within 45 days of the order. Cash refunds are not available on progressive (no-line) lenses. However, any patient who fails to adapt to their new progressive will have their prescription remade one time into a lens of their choice at no additional charge.

Returned non-sufficient funds checks will be charged a service fee of $20.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO SULLIVAN FAMILY EYE CARE FOR ANY AND ALL SERVICES RENDERED TO ME BY SULLIVAN FAMILY EYE CARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. You may refuse, in writing, the consent of disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your health information.

I RELEASE ANY INFORMATION REGARDING MY TREATMENT OR CONDIDITON IN ORDER TO OBTAIN PAYMENT FOR SERVICES AND MATERIALS.

I have been provided an opportunity to review the Notice of Privacy Practices of Sullivan Family Eye Care.

I HAVE READ AND AGREE TO THE PAYMENT/PRIVACY POLICY STATED ABOVE.

Signature _____ Date _____